



Ombudsman's Commentary

APRIL 2008 REPORTS

I laid 28 investigation reports before the Scottish Parliament today. Thirteen relate to the health sector, nine to the local government sector, five to housing associations and one to further and higher education.

Ombudsman's Overview

In this month's Overview, I am drawing attention to a number of subjects that emerge from investigations in two different sectors. I also consider what I believe is a key function of my office, namely restoring people's trust in public services on those occasions when they believe something has gone wrong.

In the **health** sector I note that several issues persistently recur: poor care of the elderly, record-keeping and communication. In two reports (cases 200502065, 200602811) I highlight concerns about delays in providing the results of CT scans. A further issue that emerges this month is consent in relation to treatment (case 200701066). My investigation found that while a patient had signed the appropriate documents giving her consent, the process for obtaining that consent lacked any clear opportunity to confirm her understanding of what was involved. I upheld her complaint and would draw this case to the attention of all Boards. I am pleased to note that, coincidentally, new guidance ('Consent: Patients and Doctors Making Decisions Together') is to be issued by the General Medical Council in May.

Of the nine reports about **local government** this month, five are about planning issues. In two we upheld some aspects of the complaints, and in three we did not uphold any aspects. As I have stated previously (see, for example, my November 2007 Commentary), there is considerable public confusion about the operation of the planning system – applicants are not always sure how to challenge or appeal the decisions reached by planning authorities and often approach the SPSO expecting that we can overturn a decision. We cannot re-examine the

merits of a decision – we can only investigate whether decisions have been reached following the proper process and procedures.

Rebuilding public confidence

It is a fact of life that despite the best efforts of those who oversee and deliver public services, there will always be occasions when things go wrong. That is why, I believe, it is of fundamental importance that the public has recourse to an independent, impartial service that will, at no direct cost to the individual, investigate the actions of public bodies to ensure they are meeting the high standards to which they aspire and to which we would all wish them to adhere. If I find that something has gone wrong, the public has the right to expect that there will be changes, and my recommendations aim to ensure, as far as possible, that there will be no recurrence of the problem. In this way, I believe my office, by safeguarding and reassuring the public, plays an important role in rebuilding the public's confidence in the services we all use.

Professor Alice Brown, Ombudsman 23.04.2008

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Details of the reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Care of the elderly: clinical treatment, discharge planning Tayside NHS Board (200603082)

Mr C raised a number of concerns about a lack of physiotherapy assessment, provision and follow-up as well as the quality of the in-patient care provided and the overall discharge planning by the Board following his late mother, Mrs A's, admission to hospital. Mr C considered that these many failures had hastened his mother's death. Mr C was also dissatisfied with the Board's responses to his concerns which he considered to be deliberately confusing and contradictory.

I fully upheld the complaint that the Board failed to properly assess and provide appropriate care and treatment to Mrs A. In my conclusion I state:

'There appear to have been multiple failures in this case. All the Advisers have told me that in their view Mrs A was discharged sooner than was clinically appropriate (even where discharge was to a nursing home) and that the care in the Hospital was not holistic but focussed on the hip fracture and immediate post-operative needs. ... It is not clear to me why a process for managing orthopaedic early discharge patients apparently exists but was not applicable in this case. I conclude there were failures to properly assess Mrs A's overall health while she was an in-patient, to properly plan and provide information to the Nursing Home on discharge and in the inflexibility of the community physiotherapy guidelines.'

By way of redress, I recommended that the Board reflect on the failures identified by the Advisers in the management of Mrs A as part of the on-going reviews already being undertaken by the Board; monitor compliance with the revised template for the discharge letter as part of the existing review of record-keeping; and review the Guidelines for (physiotherapy) Referrals and consider specifically how it impacts on those discharged to a nursing home (particularly in light of the Advisers' comments that this appears to be discriminating against such patients).

Clinical treatment, consent, follow-up care Tayside NHS Board (200701066)

I fully upheld Mrs C's complaints that the Board failed to obtain informed consent for spinal anaesthesia, performed an operation which was different to the planned haemorrhoidectomy without appropriate explanation of the new procedure and failed to provide the necessary follow-up care and treatment. I, therefore, recommended that the Board apologise to Mrs C for the failure to ensure she adequately understood and consented to the anaesthetic options, and use the events of this case and in particular Mrs C's experience, as part of induction and training programmes about the consent process.

Clinical treatment, complaint handling Greater Glasgow and Clyde NHS Board (200502428)

Mr C complained that his 84-year old partner, Ms A, did not receive professional care and treatment for a urology problem from hospital staff. He also considered that the former Argyll and Clyde NHS Board failed to deal with his complaint appropriately. I upheld the complaint that treatment was inadequate prior to and after Ms A's day surgery and partially upheld the complaint that the Board failed to adequately address Mr C's complaint in their response to him.

I recommended that the Board apologise to Ms A and Mr C for the distress and pain caused and ask staff at the Hospital's Day Surgery Unit to review their practice for Endoscopy procedure preparation, and benchmark that practice against other similar units within the Board area. This would form part of the work already in progress to review pre-assessment practice for day surgery throughout the Board area.

Clinical treatment, record keeping, communication, complaint handling Greater Glasgow and Clyde NHS Board (200502554)

Ms C raised a number of concerns about the care and treatment given to her late father, Mr A, from the day he was admitted to hospital up to his death there three days later. Ms C also complained that the Hospital's communication with her during this period was poor – she lived a considerable distance from the Hospital and complained that, despite her telephone contacts with the Hospital from the time of her father's admission to the time he died, she was not informed at any time of the seriousness of his condition. She also complained that her subsequent complaint to the Board was dealt with inadequately.

I did not uphold the complaint about care and treatment but I did find fault with communication, record keeping and complaint handling. I made a number of recommendations, including that the Board advise me on the steps they have taken to avoid breakdowns in communication recurring; advise me on the steps they have taken to avoid medical notes being unavailable; emphasise to staff the need to adhere to the terms of the NHS guidance for dealing with complaints and ensure that their records are updated when a patient dies; and apologise to Ms C.

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Health

Delay in diagnosis, staff attitude Greater Glasgow and Clyde NHS Board - Acute Services Division (200603801)

Mrs C felt that the death of her husband, Mr C, could have been avoided had staff of the Board been more proactive in diagnosing his condition. She complained that Mr C's assigned consultant should have been more directly involved in his care. I did not uphold the complaint about the consultant's involvement, but I did find that the diagnostic process was unnecessarily delayed. I made no finding on the complaint that ward staff did not deal with Mr C respectfully.

I recommended that the Board consider asking the clinical team to review the circumstances of this case to see if there are any lessons to be learned regarding communication with patients and relatives. I also recommended that they apologise to Mrs C and her family for the additional distress and suffering caused by the delays to Mr C's diagnosis; and revise their procedures to include written notice to the referring consultant of all failed scan results.

Clinical treatment, hospital discharge Lothian NHS Board (200601244)

I partially upheld complaints by two daughters about their mother's, Mrs A's, treatment and care in hospital and I fully upheld their complaint that the Board failed to properly plan for Mrs A's discharge. I made several recommendations to the Board, including that they:

- (i) ensure that discussions take place within the clinical team on a particular ward of the Hospital to agree the appropriate standard of practice with regards to the importance of a) thorough examination of a patient prior to discharge, with particular reference to patients with pre-existing medical problems and multiple medications, and b) recording of medical examination findings and the rationale behind any changes to medications;

- (ii) consider the use of fully unified records, i.e. including therapy follow-up records with the joint medical/nursing records;
- (iii) consider regular (at least weekly) multi-disciplinary team meetings where discharge planning for complex cases, particularly for elderly patients, can be discussed, coordinated and recorded;
- (iv) consider that where family conflicts or carer anxieties are raised, case conference meetings are organised when the key disciplines and family and carers can meet to exchange information and plan discharges and that all family meetings are adequately recorded; and
- (v) consider whether current occupational therapist staffing levels in this area are sufficient to avoid the delays experienced by Mrs A.

Diagnosis Lothian NHS Board and a GP Practice in Lothian NHS Board (200603138, 200603250)

Mrs C complained that a GP Practice and a Hospital failed to examine her mother, Mrs A, thoroughly enough to correctly diagnose her broken hip. She felt that Mrs A suffered unnecessary pain and limited mobility due to incomplete examinations and assumptions being made by staff of both bodies. I did not uphold the complaint that the GP Practice misdiagnosed Mrs A's broken hip as arthritis, nor that they failed to follow correct procedures to consider any problems other than arthritis. However, I did consider that more could have been done by the hospital staff to eliminate all possible causes of the patient's symptoms. By way of redress, I recommended that the Board review the hospital admissions procedures to ensure that all patients receive a full diagnostic assessment prior to the commencement of treatment.

Clinical treatment, complaint handling Fife NHS Board (200502602)

Mrs C raised concerns that her late father, Mr A, had not received adequate and appropriate care and treatment from the Board, that the Board had not adequately responded to her complaints and that the action plan generated as a result of her complaints was not adequate.

Mr A, who was 79 and suffered from prostate cancer, was treated in four separate hospitals and I upheld complaints that his medical treatment and care were inadequate and unsatisfactory in two of them, and did not uphold the complaint about two others hospitals. In one of the hospitals I found serious issues about the care and treatment Mr A received. I partially upheld the complaint that the Board did not adequately respond to Mrs C's complaints and also partially upheld the complaint that the action plan generated as a result of Mrs C's complaints was not adequate.

I made eight recommendations for redress, including apologies to Mr A's family for the inadequate care and treatment Mr A received, and reviews of procedures on the investigation of symptoms of cancer of the prostate. Other recommendations included improvements to access to a call bell system, communication of information between departments and wards and the procedures ward staff follow when assessing a patient's well-being on the ward. I also recommended that a Hospital undertake a full audit of their record-keeping procedures, guidance and training, and strengthen these as necessary. I am pleased to report that the Board have already taken steps to address many of the failings identified in my report.

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Health

Hospital referral, delay in diagnosis

A GP Practice in Tayside NHS Board and Tayside NHS Board (200502065 200502179)

The complainant, Mrs C, raised a number of concerns about the treatment her late husband, Mr C, received from his GP and in hospital. Mrs C complained this led to an unreasonable delay in diagnosing that Mr C was suffering from colon cancer, which later spread to his liver. I did not uphold the complaint that there was delay by the GP in referring Mr C to the Hospital but I did uphold the complaint that there was delay by the Hospital in diagnosing Mr C's cancer and delay by the Hospital in obtaining the results of a CT scan.

By way of redress, I recommended that the Board issue Mrs C with a full formal apology for the delay in diagnosis and in obtaining the results of the CT scan and for the distress and anxiety that these failings caused. I also recommended that they review their procedures for the reporting of CT scan results, particularly where more than one hospital is involved, to ensure that delay in reporting results, such as occurred with Mr C, does not recur.

Hospital referral, district nursing care: record keeping, communication

Tayside NHS Board and a GP Practice in Tayside NHS Board (200600514 and 200800120)

Ms C raised a number of concerns that her late mother, Mrs A, had received inadequate post-operative care in her own home from her Practice GP and the District Nursing Service (the DNS) before Mrs A was re-admitted to a hospital and subsequently died. I upheld the complaints that during the period when Mrs A was receiving post-operative care within her home, the district nurses failed to enter relevant details in case notes about Mrs A's condition and that they failed to relay family concerns to the Practice GPs. I made no finding on the complaint that the GP failed to re-refer Mrs A back to the Hospital when this was requested by a district nurse.

I made a number of recommendations to redress the failings identified in my report, including that the GP reflect on comments made by my Advisers in the report and consider discussing these at her next appraisal. I also recommended that the fundamental standards of documentation are considered by the Practice and the Board and revisited across the DNS. Finally, although the services within the complaint (the Board, the Practice and the DNS) have demonstrated a willingness to deal with complaints and identify solutions, from the information reviewed, there is no evidence to suggest that any of the work/actions identified have fully addressed the fundamental areas of the need for holistic assessment and communication between teams, or been referenced to any professional standards or guidelines in relation to the assessment process, documentation, communication, wound care, care planning and patient held records. Accordingly, I recommended that these areas are explored and that I am advised of the outcome.

Care and treatment, record-keeping

Ayrshire and Arran NHS Board (200603455)

Mrs C raised a number of concerns about the care and treatment provided to her late mother, Mrs A, while she had been a hospital patient. I did not uphold her complaint that the nursing care provided was inadequate, nor that Mrs A's family was not given sufficient time to consider a proposed move of hospital. I upheld the complaint that Mrs A did not receive appropriate treatment and was wrongly prescribed a sedative. I made no finding on two other aspects of the complaint; however, in the course of the investigation I found failures in record-keeping which made it difficult for my Advisers to fully evaluate Mrs A's care.

By way of redress, I recommended that the Board apologise to Mrs C for the failures identified, provide clinical staff involved in Mrs A's care and the Board's relevant clinical director with a copy of this report; and provide evidence of the systems in place to monitor and audit medical and nursing records.

I did not uphold two other complaints in the health sector about the following issues and bodies:

Delays in medical assessment, maternity

Lothian NHS Board (200700720)

This complaint concerned a delay by staff at the Reproductive Health Department of a Hospital in examining the complainant, Mrs C, and in checking her baby's foetal heart rate. Although I did not uphold this complaint, I did recommend that the Board, as a matter of urgency, develop and implement:

- (i) a written triage protocol for patients who attend the Department; and
- (ii) a document which records the contents of telephone conversations between patients and the Department and is retained in their clinical records.

Delay in diagnosis

Tayside NHS Board (200602811)

Although I did not uphold the complaint about delay in diagnosing liver cancer, I was concerned at the length of time taken to provide CT scan results to a patient. I, therefore, recommended the Board consider ways to minimise any delays to cases being discussed by the upper gastrointestinal multi-disciplinary team.

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Local Government

Finance: council tax benefit, complaint handling South Lanarkshire Council (200602228)

I fully upheld Mr C's complaint about the way the Council administered his assessment for Council Tax benefit. There was confusion over Mr C's employment status and I felt that it took considerably longer than it should have for the Council to clarify the situation. The Council have since taken action to prevent a similar situation from happening again and have carried out a review of the self employed claim form, which makes it easier for the required information to be provided. The form also specifically asks whether the claimant or their partner are directors of a company and points out that, if they are, their Council Tax benefit will be calculated in a different way. I commended the Council for this action and further recommended that they apologise to Mr C for the delays he experienced. I also found that, although the Council felt Mr C's complaints had been addressed, they were not considered in line with the formal complaints procedure, including informing Mr C of his right to refer his complaint to my office. I therefore recommended that the Council reinforce to staff the importance of considering formal complaints in line with the Council's procedure.

Housing: repairs and maintenance East Lothian Council (200601252)

I fully upheld one aspect and partially upheld two other aspects of Ms C's complaint about delays by the Council in replacing windows in her home and carrying out a repair to a damaged window lintel, as well as about the way in which her contact with the Council was recorded. Although I noted the Council's statement that there were mitigating circumstances in this case, there was an unfortunate delay in replacing the windows. I also did not consider that the explanations given by the Council accounted for the specific delay in repairing the damaged lintel. I recommended that the Council apologise to Ms C for the delays that occurred. Whilst I do not expect the Council to record each and every telephone

call, I do believe it is essential that works orders are properly recorded and their current status kept up-to-date. In this case, there was evidence of delays in processing works orders. If these orders had initially been entered without delay, staff would have been able to give Ms C clear advice on targets for the work, which would have prevented her having to make a series of telephone calls to the Council. I recommended that the Council make Ms C an appropriate payment in recognition of the costs that she incurred in pursuing matters with them.

Planning: enforcement, complaint handling Fife Council (200603184)

I partially upheld the planning aspects of a couple's complaint about how the Council handled their representations about breaches of a planning consent for a change of use of adjacent premises to a restaurant / takeaway. Although the Council tried to mitigate the effects of the premises on neighbours by controlling hours of operation, noise and fumes, I believe that Mr and Mrs C's complaint came about due to a lack of clarity in the wording of the planning condition. This raised expectations that the Council could not meet, namely that no noise or odours from the premises would affect neighbours. I recommended that the Council review the wording of conditions used in their planning consents and that they continue to monitor compliance with the consent granted in this case.

I fully upheld the complaint that the Council took an unacceptable length of time to deal with the complaints and did not keep Mr and Mrs C properly updated. Although the Council generally responded to correspondence from Mr and Mrs C, there were specific delays and the response from the Chief Executive failed to comment on the service delivery by the two Council services involved. I recommended that the Council apologise for the failings identified.

Education: policy / administration, school exclusion

Clackmannanshire Council (200602270)

Mrs C raised a number of complaints about the way her daughter's, Miss C's, exclusion from a school in the Council area was handled. I upheld three aspects of the complaint, specifically about a failure in communication over when Miss C's exclusion would end and the date she could return to school and a failure to give Miss C direct teaching input during her exclusion from school. During my investigation I found that there were some discrepancies in the Council's exclusion practice compared to their published policy, and so recommended that the Council either review their Exclusion Policy to match their normal practice or take steps to ensure that their normal practice is in line with their current Exclusion Policy. I further recommended that the Council apologise to Miss C for their failure to provide her with direct teaching input during her period of exclusion from school and remind the school involved of the requirements of the Exclusion Policy so that, in future, arrangements are made for pupils with a Stage 3 exclusion to receive direct teaching input.

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Local Government

Handling of planning application, complaint handling South Lanarkshire Council (200603125)

I partially upheld two aspects of Mr C's complaint about the Council's handling of his enquiries concerning outline planning permission for the construction of a one bedroom single storey dwelling on land adjacent to his home. Although I accepted that on occasion, Council resources may be strained and in this case the Council had genuine reasons for being unable to deal with Mr C's enquiry within the timescales specified in their guidance for dealing with customer enquiries, they failed to acknowledge Mr C's letter within the time limit and did not advise him that they would be unable to meet the deadline for a response. It was evident that Mr C was becoming increasingly anxious about the lack of response from the Council and an acknowledgement letter and explanation for the delay may have helped ease some of this anxiety. I recommended that the Council apologise to Mr C for failing to deal with his enquiry in accordance with their Guidance and give feedback to the staff involved in this case on timescales. I also recommended that the Council apologise to Mr C for failing to adequately address all the issues raised in his complaints.

I did not uphold four other complaints in the local government sector about the following issues and bodies:

Handling of planning application Fife Council (200600058)

Handling of planning application The Highland Council (200502749)

Handling of planning application The Highland Council (200603584, 200603889)

Roads and transport: traffic calming, consultation West Lothian Council (200503539)

Housing

Provision of meals service, complaint handling Viewpoint Housing Association Ltd (200600929)

I upheld this complaint by Mr C that the Association took a decision to withdraw a meals service provided to his mother-in-law, Mrs A, contrary to the terms of her tenancy. He also complained that his complaint had not been adequately responded to. The Association could not produce any evidence of meaningful discussion with Mrs A over the withdrawal of the service and I found their consultation via the Tenant's Newsletter to be vague and generalised. There was also no specific mention of withdrawing the service in the minutes of the Tenant's Forum. I therefore considered that the Association did not meet the requirements of Housing (Scotland) Act 2001 to consult tenants about proposals related to standards of service or housing management. I recommended that the Association apologise to Mrs A for varying her tenancy agreement without adequate consultation and that they ensure that future tenant consultations are meaningful and properly recorded. I identified administrative errors in the Association's response to Mr C's complaints and recommended that the Association apologise to Mr C for these errors.

Policy / administration Fife Housing Association Ltd (200701685)

I partially upheld one aspect of this complaint by a couple who raised a number of concerns about the Association's actions in regard to an extension built by their neighbour, Mrs N. The complainants reported to the Association that the extension encroached into their tenancy. My investigation found that it would have been difficult for the Association to have established whether there was encroachment but that they could have made enquiries to check Mrs N's title deeds at the outset and fully considered their then position as feu

superior. The Abolition of the Feudal Tenure etc (Scotland) Act 2000 removed the requirement for feu superior consent for external alterations to ex-local authority properties, so I have no recommendations to make in this case.

I did not uphold three other complaints in the housing sector about the following issues and bodies:

Neighbour Problems Cairn Housing Association Ltd (200700150)

Although I did not uphold this complaint, I recommended that the Association consider offering an alternative means of dispute resolution outwith the formal complaints procedure.

Neighbour problems, complaint handling Clydesdale Housing Association Ltd (200601742)

Although I did not uphold this complaint, I recommended that the Association consider taking steps to try to encourage the complainants and their neighbours to participate in mediation.

Policy / administration, neighbour problems New Shaws Housing Association Ltd (200503246)

Although I did not uphold this complaint, I recommended that the Association consider ways of recording the information and leaflets provided to tenants by their Housing Offices at the point of completing missives.

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Further and Higher Education

Academic appeals

University of Glasgow
(200600124)

I upheld one aspect of this complaint by Mr C who raised concerns about the way the University dealt with his appeal about their decision to award him an honours degree in a class lower than he felt should have received. I found that the University took too long to consider and reach a decision on Mr C's appeal and recommended that they apologise to him for this. The University have acknowledged the delay and expressed regret at the length of time taken for the appeal to reach a conclusion. It is clear from documentation that this concern has been communicated to senior levels within the University, however it is not clear what action the University has taken to prevent a similar situation happening again. I therefore recommended that the University advise me on what steps they have taken to ensure such delays in conducting and concluding appeals do not recur.

Compliance and Follow-up

In line with SPSO practice, my Office will follow up with the organisations to ensure that they implement the actions to which they have agreed.

The compendium of reports can be found on our website, www.spsso.org.uk

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The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

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